Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016133	A. BUILDING: _____ B. WING _____	10/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR COURT OF FREEPORT	2170 WEST NAVAJO DRIVE FREEPORT, IL 61032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)5) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: d) Pursuant to subsection (a), general nursing	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act) These Requirements are not met as evidenced by: Based on observation, interviews, and record review, the facility failed to assess, monitor, and provide interventions to prevent pressure ulcers. The facility's failure resulted in R100 developing a stage III pressure ulcer. The facility failed to implement interventions to promote healing and prevent multiple recurrent pressure ulcers on a resident (R92) with minimal risk for the development of a pressure ulcer. This applies to 2 of 7 residents (R100, R92) reviewed for pressure ulcers in the sample of 22. The findings include:	S9999		

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1. The facility's electronic continuity of care document shows R100 was admitted to the facility on May 12, 2015 with the diagnoses of Hypertensive heart and chronic kidney disease with heart failure, vascular dementia without behavior disturbance, anxiety disorder, other specific arthropathies not elsewhere classified, left knee, anemia in chronic kidney disease.

The Facility's Admission Body Assessment dated May 12, 2015 showed that R100 was admitted on May 12, 2015 with no pressure sores. The Braden skin assessment dated August 21, 2015 showed R100 has a high risk for the development of pressure ulcers.

On October 14, 2015 at 10:20 AM, E10, Licensed Practical Nurse (LPN) and E12, Certified Nursing Assistant (CNA) were doing a dressing change to the pressure area located on R100's coccyx. R100 had an open area the size of a half dollar with slough present on the top edge and the wound bed. There was tunneling present under the wound.
edges. The peri-wound area was reddened. E10 cleansed the wound bed with wound cleanser and applied lidocaine to the wound bed. After a few minutes, E10 packed R100's wound with calcium alginate. E10 said "She's (R100) a real trooper, she only flinched a couple times. Before she would be jumping quite a bit during the dressing change." E10 said, "It used to be where you could pretty much see the bone." E10 said there was some slight drainage to the wound. E10 said there was one day that she removed the dressing to change it and there was a very foul odor and purulent drainage was present. E10 said she was unsure of the date this occurred, but it was not that long ago.

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S9999	Continued From page 3 On October 15, 2015 at 9:00 AM, E2, Director of Nursing (DON) stated, "I did not find a Braden Assessment (Pressure ulcer risk assessment tool) for R100 on admit." E2 said the Braden Assessment dated August 21, 2015 was the only one she could find. E2 said the approaches listed on the care plan dated May 12, 2015 were to encourage resident to attend activities to promote change of position. On October 16, 2015 at 8:35 AM, E2 said "Considering her (R100) medical condition, I would expect there to be interventions put in place to reduce pressure. The interventions should have been updated as she (R100) declined." E2 said if the CNAs, Shift coordinators, or Nurses see something that needs to be changed, they let the MDS (Minimum Data Set) Coordinator know and they would add it to the resident's care plan. On October 15, 2015 at 12:00 noon, E2 said the CNAs should let the nurses know when there is a red area or they have any concerns, so they can get a treatment in place. E2 stated, "I would expect the CNAs to notice an area of pressure prior to stage III or unstageable." E2 said she would expect them to notice it when it is red. (stage I) On October 15, 2015 at 10:55 AM, Z1 (Wound Care Consultant from American Medical Technology) stated the pressure ulcer located on R100's left inner buttocks was a stage III the first day that she looked at it on July 21, 2015. Z1 said the pressure ulcer on R100's coccyx was unstageable when she first observed it. Z1 stated she would expect the facility to notify her prior to a stage III or unstageable pressure ulcer.	S9999		

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S9999	Continued From page 4 On October 16, 2015 at 8:35 AM, E2 (DON) stated R100's pressure ulcer was facility acquired. On October 16, 2015 at 2:02 PM, Z2 (Nurse Practitioner) said you would see reddened skin that was unblanchable prior to the development of a pressure ulcer. If a pressure ulcer is not identified and treated, it would get worse and it is easier to treat at the earlier stages. Z2 stated, "Stage III is not an acceptable stage to identify a pressure ulcer." Resident Progress Nursing Notes reviewed from May 12, 2015 through October 15, 2015. No mention of R100 having a pressure ulcer was in nursing notes until July 14, 2015 at 12:47 PM. The Nursing Notes showed a stage III pressure ulcer noted to R100's coccyx measuring 1.2 x 1.2 x 2 cm. The nursing notes dated July 16, 2014 show a stage II pressure ulcer on R100's medial aspect of left buttocks measuring 1.0 x 1.0 x 0.1 cm. The Nursing Notes dated August 18, 2015 showed the wound nurse assessed R100 and recommended Lidocaine put in wound and on peri-wound 30 seconds before dressing change. The Facility's Observation Reports for R100 show that the pressure ulcer on R100's coccyx deteriorated from a stage III measuring 2 x 1.5 x 0.1 cm on July 16, 2015 to a stage IV pressure ulcer with heavy, cloudy serosanguinous drainage and undermining on October 1, 2015. R100's Facility's Observation Report related to pressure ulcer documentation of her left buttocks wound, dated July 16, 2015 showed she had a stage II pressure ulcer on her left medial buttocks that measured 1 x 1 x 0.1 cm with no drainage.	S9999		

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Z1's (Certified Wound Care Consultant) evaluation of R100 dated July 21, 2015 showed R100 had a stage III pressure ulcer on her left inner buttock measuring 3.4 x 3.5 cm with serous drainage that was facility acquired. Z1's evaluation showed that the pressure ulcer on R100's coccyx deteriorated from unstageable measuring 2.5 x 2.3 cm with slough (non-viable, dead tissue) in the wound bed on July 21, 2015, to a stage III pressure ulcer with undermining on September 5, 2015, to unstageable measuring 3.5 x 2 cm with the depth of the wound unable to be determined due to ivory slough covering half of the wound bed on October 13, 2015 (3 months later).

R100's Care Plan for pressure ulcer risk start date May 12, 2015 showed "(R100) is at risk for pressure ulcer formation related to weakness and immobility as evidenced by diagnosis of CHF (Chronic Heart Failure)." The Care Plan showed interventions implemented at that time were encourage resident to attend activities of choice to promote position change, and encourage (R100) to attend activities outside of her room to promote position change. The Care Plan showed that no further interventions were initiated until after July 14, 2015 (after R100 developed pressure ulcer on coccyx).

The Facility's Pressure Ulcer Prevention and Treatment Protocol Revised May 2007 showed a skin risk assessment is completed upon admission , weekly for the first four weeks after admission and quarterly thereafter. The protocol shows an individual plan of care will be developed for the resident following the guidelines of the

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assessment. All high and moderate risk residents may have the following, and if so, they will be addressed on the Care Plan. A)special mattress and wheelchair cushions, B) Passive Range of Motion, C) Protein and/or Nutritional Supplements, E) Skin checks, F) Elbow/heel protectors. The Protocol shows "Staff will be trained on pressure ulcer prevention and safety measures to be taken, including redness that remains when pressure is relieved and proper positioning procedures. The protocol lists chronic or end stage renal, liver or heart disease, and anemia as some of the predisposing factors. R100's MDS dated August 25, 2015 showed R100 has the diagnosis of renal insufficiency renal failure, or end-stage renal disease

The facility's Care Plan policy and procedures revised November 2013 shows The care plan meeting provides a framework for providing good resident care and sets direction for meeting the needs of the individual resident. It provides a valuable communication tool for staff to ensure that individual plan of care is carried out. The document shows if the need arises that indicates that the plan of care needs to be reviewed prior to the three month review, a special care plan meeting shall be held.

R100's Treatment Administration History showed R100 had a weekly skin check starting May 20, 2015. The Treatment history showed no documentation regarding a pressure ulcer until July 15, 2015. The document showed orders to clean stage III decubitus, apply skin prep to peri-wound bed and cover with bordered foam every day. The Documentation from July 16, 2015 shows orders to apply collagen to stage II pressure ulcer on left buttock and cover wit bordered foam until resolved. The Treatment

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Administration History showed that on July 21, 2015 there was an order to cleanse stage III decubitus cluster to coccyx. Apply skin prep and hydrogel disc to wound and cover with white bordered foam dressing every day.

The Facility's Observation Report related to pressure ulcer documentation of R100's coccyx wound showed between July 23, 2015 and August 13, 2015 R100's pain level increased from a 4 out of 10 moderate (distressing/miserable) pain at the ulcer site on July 23, 2015 to a 9 out of 10 (10 being excruciating, worst possible pain-interferes with ability to carry on with daily routines, socialization, or sleep) before orders were obtained for pain control prior to packing R100's wound.

The Facility's electronic Current Orders for R100 show "Lidocaine Ointment squirt some in wound bed and gently spread with swab, wait 30 seconds to pack wound." was ordered on August 19, 2015. On August 21, 2015 "Morphine 100 mg/5 ml (20 mg/ml) Give 0.75 ml 30 minutes prior to dressing change." was ordered. R100 went from July 14, 2015 to August 19, 2015 before the facility addressed her pain.

2. The September 29, 2015 MDS (Minimum Data Set) shows R92's diagnoses to include, muscle weakness, insomnia, diabetes mellitus, neurogenic bowel and bladder, joint pain, and atrial fibrillation.

The nursing notes document that R2 had developed a pressure wound (at the facility). On December 16, 2014 nursing notes show R92's wound measured 0.5 cm (centimeter) x 1 cm on the coccyx and the notes show R92's wound continued to worsen, increasing in both area and

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depth: Stage 2 (0.7 cm x 0.6 cm) on January 1, 2015, Stage 2 (2.5 cm x 2. 4cm x 0. 4cm) on January 15, 2015 and Stage 3 (5.0 cm x 2.5 cm x 0.1 cm) on February 3, 2015.

The nursing notes shows a Stage 2 pressure ulcer Mw on R92's sacrum (lower back) was identified on April 24, 2015. The wound measured 2.0 cm x 1.3 cm x 0.1 cm. On May 26, 2015 the contracted wound care nurse measured the same wound as 0.5 cm x 2.5 cm x 0.1 cm and rated the pressure wound at a facility acquired Stage 3 (Full Thickness Pressure Wound).

On September 8, 2015 at 2:59 PM the nursing notes by E14 RN (registered nurse) shows 2 new Stage 2 pressure ulcer on R92's coccyx area, measured at 1.0 cm x 0.2 cm x <0.1 cm and 0.8 cm x 0.2 cm x <0.1 cm. One week later, on September 14, 2015 R92's wound measured 0.8 cm x 0.2 cm x<0.1 cm.

The following Braden Risk Assessments were completed for R92:
1. February 2015 - Score of 16 (At [low] risk for developing pressure ulcers;
2. April 2015 - Score of 19 (Not at risk); and
3. September - Score of 23 (Not at risk).

The Braden Scale shows, 19 or higher-NOT AT RISK, 15-18 AT RISK, 13-14 MODERATE RISK, 10-12 HIGH RISK, and 9 or less VERY HIGH RISK.

R92's care plan shows "Skin Integrity" was first added to the plan of care on February 11, 2015, nearly two months (56 days) after R92 had developed a pressure wound. There were no documented interventions identified to prevent

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R92 from developing a new pressure wound.

On October 15, 2015 at 10:15 AM, E3, ADON (Assistant Director of Nursing) said, it was her expectation that no residents received a facility acquired pressure ulcer, and if a resident did receive a pressure ulcer that it did not progress to a higher stage. E3 would also expect the care plans to be initiated for a new pressure ulcer, or modified if the pressure ulcer does not heal or worsens.

On October 15, 2015 at 2:47 PM, E2 DON (Director of Nurses) said, it would be her expectation that no residents receive a facility acquired pressure ulcer, and if a resident did receive a pressure ulcer that it did not progress to a higher stage. E2 would also expect a care plan to be initiated if the pressure ulcer is new, or modified if the pressure ulcer is not healing or getting worse.

The May, 2007 Pressure Ulcer Prevention and Treatment Protocol shows, under the heading, Objective and Purpose: To ensure that measures are taken to prevent skin breakdown and to provide guidelines for treatment of any pressure ulcer that might develop. The same protocol list one of the treatment measures as providing pressure relieving devices.

The November, 2013 Care Plan Policy and procedure shows, care plans provide a valuable communication tool for staff to ensure that individual plan of care is carried out. Under the heading, Frequency of Care Plan Meetings...#4 Special Review: If the need arises that indicates that the plan of care needs to be reviewed...a special care plan meeting will be held.

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(B)

300.690b)

300.690 Incidents and Accidents

b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.

This REQUIREMENT was not met as evidenced by:

Based on observation, interview and record review, the facility failed to report a fall with a resultant head injury to the state agency. This fall and injury required the resident to be sent to the hospital for treatment and monitoring for more than 36 hours.

This applies to 1 of 5 residents (R61) reviewed for falls in the sample of 22.

The findings include:

On October 13, 2015 at 12:30 PM, R61 was seated in his wheelchair in the dining room of the Specialty Care Unit. R61 had a large foam (4 inches X 4 inches) dressing to the posterior crown of his head. The dressing was dated October 11, 2015.

On October 13, 2015 at 1:02 PM, R61 stated he fell while in the "nursing home" portion of the facility (1 month ago). R61 said he did not realize the injury "was such a big deal." R61 said the staff are still applying "a bandage 3 times the size

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it probably needs to be" on his head and changed every three days.

On October 14, 2015, at 1:10 PM, E13 LPN (Licensed Practical Nurse) cleansed the wound and changed the dressing to R61's head. The wound had dried scabbing to the large U shaped laceration to the head. The area of injury was large enough to still require the 4 X 4 foam dressing bandage.

The facility face sheet in the electronic medical record showed R61 was admitted to the facility with diagnoses to include history of falls, aftercare for a traumatic hip fracture, UTI (urinary tract infections), dementia and Alzheimer's Disease. The face sheet showed on September 15, 2015, R61 was in a room located at the end of the hallway furthest away from the nurses station.

The electronic medical record showed R61 had a fall in July 2015 with a resultant hip fracture. R61 rehabilitated at the facility until September 11, 2015 at which time he was discharged home. R61 returned to the facility on September 14, 2015 due to continued falls.

The care plan initiated September 14, 2015, titled RCIS (Resident Care Information Sheet) identified R61 as being on the alternate call light program (to be checked by staff every 30 minutes.)

The electronic medical record nursing note dated September 15, 2015 at 5:15 AM showed "Res. (resident R61) noted lying on floor next to bed. Head and left elbow bleeding. U shaped laceration to back of head. Laceration is not deep but keeps bleeding. 4 x 4's applied and band of kerlix wrapped around crown of head to apply

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pressure. Skin tear to L (left) elbow cleansed with wound cleanser and wide band aid applied. No shortening noted. Res. does not respond to hand grasps. Eyes do not respond. Does not complain of pain."

The local hospital records showed R61 had a CT (Computerized Tomography) of the brain with sagittal and coronal imaging in addition to a CT of his cervical spine related to a "Fall with altered mental status." Other hospital procedures included a chest X-Ray for "Trauma with altered mental status," and pelvis/hip X-Rays for "Trauma with Rt (right) hip pain." The September 16, 2015 hospital physician progress note timed 11:24 AM documented that R61 became more responsive "later in the day" (September 15, 2015).

The facility nursing note dated September 16, 2015 at 11:31 PM showed the following documentation; "Resident (R61) re-admitted to Manor court from (local hospital) today. Alert to self, confused. Vital signs BP (blood pressure) 136/78, T (temperature) 98.7, P (pulse) 72, R (respirations) 18. Wife was here with him. S1 and S2 heart sounds heard. LS (lung sounds) clear. BS (bowel sounds) active x 4. Skin pink, warm, and dry. Has laceration to back of head that was cleansed and bordered gauze applied, laceration to right elbow that shows no signs and symptoms of infection with that was cleansed and bordered gauze applied, laceration to left elbow with tegaderm intact. He has multiple bruises to both lower arms purple in color and healing sores on both knees." A later nursing note entry mentions R61's head wound.
On October 14, 2015 at 10:30 AM, E3 ADON (Assistant Director of Nursing) was asked about the reporting of R61's fall/injury. E3 stated she typically handles concerns brought to her by the

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR COURT OF FREEPORT	2170 WEST NAVAJO DRIVE FREEPORT, IL 61032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 13 CNA's (Certified Nursing Assistant's) unless she is the on call supervisor. E3 stated she was aware of R61's fall but has no idea why it was not reported to the state agency. On October 15, 2015 at 10:45 AM, E2 DON (Director of Nursing) stated any resident that has a fall with a fracture or a fall with an injury requiring hospital treatment is reported to the state agency. E2 stated she is unsure as to why R61's injury was not reported. E2 said E1 (Administrator) and herself were out of town so "I believe (E3) was on call and should have taken care of that." E2 then stated that E3 was also out of town with E1 and E2 however, it still would have been her responsibility to ensure someone at the facility faxed the report to the state agency. On October 15, 2015 at 10:55 AM, E3 was informed of E2's statements. E3 stated she did not recall specifically but that she did not notify the state agency of R61's injury and hospitalization. (B)	S9999		